GENETICALLY HANDICAPPED PERSONS PROGRAM (GHPP)
INITIAL/ANNUAL INCOME VERIFICATION

Refer to the Instructions When Filling in this Application

The following information is required by the GHPP to determine your enrollment fee amount, if any. Your enrollment fee is based upon your family gross income for the previous year. Your income information is reviewed annually, and therefore your enrollment fee may change from year to year.

Section A: Personal Information

1. Name (Last) (First) (MI)			2. Social Security Number (OPTIONAL)
3. Address (number, street, apartment #)	City	County	Zip Code
4. Daytime Telephone Number (include area code) ( )	5. Evening Telephone Number (include area code) ( )		

Section B: Income Verification

6. Family Gross Income
$

7. List Income Data Source(s) and Attach Copies

8. Family Size _____ List Family Members, Including Yourself, Who Are Dependent on the Family Income

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

(Use additional sheets if more space is needed)

9. Employment Information

Your Employer's Name _____

Employer's Telephone Number (_____)_____

Employer's Address_____

Section C: Enrollment Fee Information

NOTIFICATION OF ENROLLMENT FEE STATUS:

a. When the GHPP has calculated the amount of your enrollment fee, you will be sent a written notification. The total enrollment fee will be provided on an Enrollment Fee Agreement. The Enrollment Fee Agreement will specify the amount owed and two options for payment:
   i. One lump sum due no later than the 60th day from the date of notification from the GHPP, or
   ii. Two or three payments which are due no later than the 60th, 120th, and 180th days from the date of notification from the GHPP.

b. **FAILURE TO PAY THE ENROLLMENT FEE ACCORDING TO THE SIGNED AGREEMENT WILL RESULT IN CLOSURE OF YOUR CASE ON THE 61ST, 121ST, OR 181ST DAY FROM THE DATE OF NOTIFICATION FROM THE GHPP.**

GENETICALLY HANDICAPPED PERSONS PROGRAM (GHPP)
ANNUAL INCOME VERIFICATION
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Section D: Certification

Read and Initial Each Statement Below:

_____I understand that my enrollment fee, if any, will be based on my stated income and that my enrollment fee may change annually if my income changes.

_____I give my permission for the GHPP to verify my income and/or other circumstances which may be required to determine my annual enrollment fee, if any.

_____I certify that I have read this information, or had it read to me, and that I understand it.

_____I certify that the information I have given on this form is true and correct to the best of my knowledge.

Signature of GHPP Applicant/Client or Parent/Legal Guardian of minor child:		Relationship to Minor Child:	Date:
_____		_____	_____
If Signing with an "X," Signature of Witness: _____ Print name _____	Relationship of Witness to GHPP Applicant/Client: _____	Witness Telephone Number: (____)_____	Date: _____

California law requires that families applying for services be given information on how GHPP protects their privacy. [1]

To protect your privacy:

- GHPP must keep this information confidential.[2]
- GHPP may share information on the form with authorized staff from other health and welfare programs **only** when you have signed a consent form.

You have the right to see your application and GHPP records concerning you. If you wish to see these records contact the GHPP at 1 (916) 327-0470 or toll free at 1 (800) 639-0597. By law, the information you give GHPP is kept by the program.[3]

1 Civil Code, Section 1798.17
2 In accordance with Section 41670, Title 22, California Code of Regulations and the California Public Records Act (Government Code, Sections 6250-6255)
3 Section 123800 et. seq. of the California Health and Safety Code

INSTRUCTIONS FOR COMPLETING
THE GENETICALLY HANDICAPPED PERSONS PROGRAM (GHPP)
INITIAL/ANNUAL INCOME VERIFICATION FORM

Please print clearly so your application can be processed as quickly as possible.

Please fill out each section completely. If you do not provide all the information requested, the GHPP will be unable to proceed with your application. If you need help in filling out this form, please contact the GHPP at 1 (916) 327-0470 or toll free at 1 (800) 639-0597. Once the application is completed, mail it to the GHPP in the envelope provided. **PLEASE REMEMBER TO SIGN AND DATE THE FORM.**

Section A: Personal Information: This includes identifying information and other information necessary to process this form.

1. **Name:** Write your last name, first name, and middle initial.

2. **Social Security Number (OPTIONAL):** Write your nine-digit Social Security Number.

3. **Address:** Write your residence street number, street name, apartment number, city, county, and zip code. Do not use a P.O. Box.

4. **Daytime telephone number:** Write the telephone number where you can be reached during the day including the area code.

5. **Evening telephone number:** Write the telephone number where you can be reached in the evening including the area code.

Section B: Income Verification: Follow the instructions for each number below. Your enrollment fee, if any, will be based upon the information you provide.

6. **Family gross income:** This is information found on your tax forms 1040 and 540. You can also use your forms W-2 and/or other documents listed below in Item 7. You must include income from members of your family who are dependent on the family income. Use the income amount from the previous year. Examples:

- If you are not claimed on anyone else's tax returns and you earn your own income, this is the amount you must report.
- If you are married you must report both your income and the income of your spouse, even if you file separately.
- If you live with a family member who claims you on their tax returns, you must use their income amount and supply copies of their tax returns.
- YOU DO NOT have to include the income from members of your household such as roommates or siblings.

If you have questions about what income you must report, please contact the GHPP.

INSTRUCTIONS FOR COMPLETING
THE GENETICALLY HANDICAPPED PERSONS PROGRAM (GHPP)
INITIAL/ANNUAL INCOME VERIFICATION FORM

7. **List income data source(s) and attach copies:** This means the document(s) you used to calculate the amount listed in Item 6. Attach a copy of any of the following documents used to calculate your family gross income.

- Federal tax forms 1040/1040A
- California State tax forms 540/540A
- Social Security income statement
- Disability income statement
- Forms W-2
- Pay stubs
- Other (please specify)

8. **Family size:** List members of your household who are dependent on the family income. Your family size is considered when calculating your enrollment fee. Attach an additional sheet if more space is needed.

9. **Employment information:** List your employer's name, telephone number, and address.

Section C: Enrollment Fee Information: Read this important information about your enrollment fee.

Section D: Certification: Read and initial the statements where indicated on the form. Then sign and date in ink in the spaces provided. If you sign your name with an "X," you must have a witness sign in the space indicated.

Submitting your application: Mail the completed form to the GHPP at: Genetically Handicapped Persons Program, MS 8100, P.O. Box 997413, Sacramento, CA 95899-7413.